

NORTH FULTON RHEUMATOLOGY, PC
ACKNOWLEDGEMENT
OF
NOTIFICATION OF HIPAA PRIVACY PRACTICES

PATIENT SECTION:

North Fulton Rheumatology, PC, (the "Practice") has provided me a copy their current Notice of Privacy Practices on the date below and in accordance with requirements of the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have been further advised that:

1. Any future changes to the Notice of Privacy Practices will be posted in the Practice office.
2. I may request additional copies of the Notice of Privacy Practices at any time.
3. I may direct my questions about the Notice of Privacy Practices to:

OFFICE MANAGER
NORTH FULTON RHEUMATOLOGY
1300 UPPER HEMBREE RD
BLDG 100-A
(770) 619-0004 / (770) 619-0252 FAX

Patient's Signature

Date Signed

Patient's Printed Name:

PRACTICE NOTES ONLY:

The patient refused to sign this Acknowledgement on: _____

The patient refused to sign because:

Employee's Signature

Date Signed

Employee's Printed Name:
